

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	0	H	D	B	S	1	2	0	0	-	0	0	N	P	F	-	0	3	3	4	1	1	1	1	4			5
7	8	9					14	15											25	26						30	57	CAT	58

REPORT
SOURCE

REPORT SOURCE	60	61	DOCKET NUMBER				66	EVENT DATE				74	REPORT DATE				80								
	L	6	0	5	0	-	0	3	4	6	7	0	4	2	2	7	8	8	0	5	1	0	1	0	9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 While reviewing the Reactor Operator Log on 4/22/78, it was discovered that the Group 5 Control Rods 100% Zone Reference Light had been last checked on 4/21/78 at 2220 hours. Since Group 5 was in asymmetric bypass, TS 3.1.3.3, Action a.2.b requires that Group 5 position be verified at least once every 12 hours. There was no danger to the health and safety of the public or unit personnel. The control rods of Group 5 were not in an asymmetric condition. (NP-33-78-50)

08		789		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE	
0	8	7	8	9	10	11	12	13	14	15	16	17	18	19	20		
09		R B		A		A		I N S T R U				Z		Z			
0	9	9	10	11	12	13	14	15				16		17			
17		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
18		7 8		0 4 0		0 3		L		1							
19		21 22		23 24 25 26		27 28 29		30 31		32							
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
X	18	Z	19	Z	20	Z	21	0 0 0	22	Y	23	N	24	Z	25	Z Z Z Z	26
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The apparent cause of this occurrence was personnel error. The operator inadvertently

1 1 failed to perform the required observation of the zone reference light. An operator

1 2 was dispatched to read the zone reference light at 2117 hours on April 22, 1978. A

1 3 program has been developed for use by the process computer to aid operators in moni-

1 4 toring surveillance tests required at frequent intervals when the unit is in an Action

Statement. 80

8 9
FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)
1 5 E (28) 0 4 6 (29) NA A (31) Operator Log Review 80
7 8 9 10 12 13 44 45 46
ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)
1 6 Z (33) Z (34) NA NA LOCATION OF RELEASE (36)
7 8 9 10 11 44 45 80

PERSONNEL EXPOSURES									
NUMBER		TYPE		DESCRIPTION					
1	7	0	0	0	(37)	Z	(38)	NA	(39)

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	NA

7		8		9		11		12	
LOSS OF OR DAMAGE TO FACILITY (43)									
TYPE		DESCRIPTION							
1	9	Z	(42)	NA					

7 9 0 3 2 7 0 6 0 0

PUBLICITY

ISSUED DESCRIPTION (45)

2 0 N (44) NA

NRC USE ONLY

PHONE: 419-259-5000, Ext. 276

TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-50

DATE OF EVENT: April 22, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure to read zone reference light for Group 5 Control Rods when in asymmetric bypass

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 1269 and Load (MWE) = 385.

Description of Occurrence: While reviewing the Reactor Operator Log on April 22, 1978, it was discovered that the Group 5 Control Rods 100% Zone Reference Light had been last checked on April 21, 1978 at 2220 hours. Since Group 5 was in asymmetric bypass, Technical Specification 3.1.3.3, Action a.2.b requires that Group 5 be maintained at 0%, 25%, 50%, 75% or 100% withdrawn and verified at least once every 12 hours. The position of Group 5 had not been verified by the 100% Zone Reference Light for approximately 24 hours.

Designation of Apparent Cause of Occurrence: The apparent cause of the occurrence was personnel error. The operator inadvertently failed to perform the required observation of the zone reference light.

Analysis of Occurrence: There was no danger to the health and safety of the public or unit personnel. The control rods of Group 5 were not in an asymmetric condition. Only the Absolute Position Indication for one control rod was defective requiring operation in asymmetric bypass.

Corrective Action: As soon as it was discovered that the zone reference light had not been read, an operator was immediately dispatched to read the zone reference light at 2117 hours on April 22, 1978. A program has been developed for use by the process computer to aid operators in monitoring surveillance tests required at frequent intervals when the unit is in an Action Statement.

Failure Data: This is not a repetitive occurrence.

LER #78-040